Section 1915(b) Montana Waiver Renewal
Proposal For
Passport to Health,
Health Improvement and
Nurse First Programs
Effective April 1, 2010 through March 31, 2012

MMA renewal version

MT02.RO8

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Proposal for a Section 1915(b) Waiver
MCO, PIHP, PAHP, and/or PCCM Program

Facesheet
Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State of Montana** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The name of the waiver programs are **Passport to Health**, **Health Improvement Program and Nurse First Program.**

Type of request. This is a:
___ initial request for new waiver. All sections are filled.
___ amendment request for existing waiver, which modifies Section/Part ____
__ Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).
__ Document is replaced in full, with changes highlighted
_X_ renewal request
__ This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
_X_ The State has used this waiver format for its previous waiver period.

Sections C and D are filled out.

Section A is _X_ replaced in full
___ carried over from previous waiver period. The State:
___ assures there are no changes in the Program Description from the previous waiver period.
___ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is _X_ replaced in full
___ carried over from previous waiver period. The State:
___ assures there are no changes in the Monitoring Plan from the previous waiver period.
___ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: *This renewal is requested for a period of two years; effective April 1, 2010 and ending March 31, 2012.*

State Contact: *The State contact person for this waiver is Mary Noel who can be reached by telephone at (406) 444-4146, or fax at (406)444-1861, or e-mail at manoel@mt.gov.*

Section A: Program Description
Part I: Program Overview

Tribal consultation
For initial and renewal waiver requests, please describe the efforts the State has made to ensure federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

During this renewal process, the State of Montana sent a notice to each Tribe, Indian Health Service and Urban Indian Center in Montana to inform them that the renewal of the waiver was taking place. The State provided information on our programs and direction on how to make comments, suggestions or request more information regarding the waiver.
See Attachment A: Letters to Tribes, Indian Health Services and Urban Indian Centers

Program History
For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

Passport to Health Program

Passport to Health is Montana Medicaid's Primary Care Case Management (PCCM) Program. Passport has been in operation since January of 1993. Passport was implemented on a county-by-county basis and serves all Montana Counties. Sanders and McCone Counties, which did not participate in Passport during previous waiver periods, were brought onto the program during 2009.

Team Care is a sub-program of Passport to Health which began operating in 2004. Clients enrolled in Team Care are restricted from changing their primary care provider (PCP) without good cause and are restricted to one pharmacy. Enrollment in Team Care is based on utilization that is found to be excessive, inappropriate or fraudulent with respect to need. Medicaid clients can be referred to Team Care by Drug Utilization Review Clinical Case Managers, PCPs, or data claims mining.

During our previous waiver period, Montana reported problems with the functionality of our enrollment broker and subsequent release of Policies Studies Incorporated (PSI) from their contract with the State. Affiliated Computer Systems (ACS), Montana's fiscal agent, stepped in to function as our enrollment broker in May of 2007. ACS took over our client helpline immediately and began to work on a new system to handle enrollment broker functions. ACS began to phase in enrollment broker functions, enrolling some clients into PCCM beginning in December 2007. Over several months ACS moved towards being a fully functional enrollment broker for the Passport Program, phasing in new populations monthly. In May, 2008 a massive enrollment for Medicaid Clients who had never been on Passport was to be the final phase of making ACS our fully functional enrollment broker. It soon came to the States attention that system problems made this mass enrollment unsuccessful. The State ordered that ACS stop enrollment into PCCM and implemented a corrective action plan at the end of June,

2008. The signed corrective action planned was forwarded to Cindy Smith at the CMS Regional Office in Denver.

Over the next several months, the State worked very closely with ACS and continued to update Cindy Smith with major milestones as the corrective action plan was implemented. In November, 2008 ACS restored enrollment broker functions and all new Medicaid managed care spans took effect by January, 2009. There were no major pitfalls with the new system. ACS continues to do an excellent job as our fully-functioning enrollment broker. We closed the corrective action plan in February, 2009 and forwarded a copy to Cindy Smith. We continue to closely monitor enrollment broker functions and they continue to meet and exceed performance measures.

Health Improvement Program

In 2009, Montana designed a new statewide Health Improvement Program (HIP) as an enhancement to Passport to Health. This enhanced PCCM will be operated through a network of Passport providers who will receive an enhanced case management fee to work with Passport eligible clients who have been identified as high risk, high cost through predictive modeling, or have been referred by a primary care provider. In addition to location, coordination and monitoring of primary health care services, enhanced services include the following:

- *Conduct patient health assessment within 30 days of State referral of patient to Provider, using an approved Health Survey. Patients who cannot be reached or who prefer not to participate in an assessment initially are placed in "on demand" status and additional contact attempts are made at least twice during the following 12 months.*
- *Provide initial and ongoing clinical assessment at pre-determined intervals such as 30, 60, 90 days and one year, depending on diseases and risks.*
- *Tailor a holistic treatment/action plan for each enrolled patient in consultation with patient's primary care provider.*
- *Manage patients as indicated—in person, telephonically, or other means suited to the individual.*
- *Provide group appointments for education and prevention when appropriate.*
- *Monitor and remind patients about routine testing; provide follow-up education regarding tests.*
- *Coordinate services with existing partners and form new partnerships (examples—hospitals, community primary care providers, specialists, social service and non-profit programs).*
- *Participate in multi-disciplinary hospital pre-discharge planning and counseling.*
- *Provide post hospital discharge visits, in-person and/or telephonic.*
- *Educate and support patients in self-management of health conditions.*
- *Be familiar with and refer patients to available local resources that can help patients with social services, housing, and other life problems that could prevent patients from paying attention to medical conditions.*
- *Track patient data—enrollment status, diseases, risks, interventions, and outcomes—and report to the State.*
- *In conjunction with the State, incorporate new methods such as remote disease monitoring or virtual video visits as technology is available and appropriate.*

- *Monitor patient progress and determine criteria for completion/graduation.* ***See Attachment B: HIP Provider Agreement***

Nurse First Program

Montana has operated our nurse advice line, Nurse First, since 2004. Through the competitive bidding process, the state contracted with a new vendor, Nurse Response. Nurse Response took over operation of Nurse First on May 1, 2009. It has been operating well since that time, adding an important component to our PCCM program.

The NAL is available to all Medicaid eligible individuals. At any time, clients can call the NAL for health information. Primary care providers receive a fax describing the patient call after each call from a patient enrolled in the Passport to Health program.

We are currently coordinating with the Public Health and Safety Division to allow them to use the nurse advice line to provide person to person telephone outreach to parents and guardians of approximately 3,000 high risk child Medicaid clients about the importance and availability of receiving H1N1 influenza vaccines.

A. Statutory Authority

1. **Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

a. X **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

b. X **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

c. ___ **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

d. X **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

___ MCO
___ PIHP
___ PAHP
_X_ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
_X_ FFS Selective Contracting program (please describe)
Nurse Advice Line

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

a.__ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State.

b._X_ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

c._X_ **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
PCCM- Passport to Health
EPCCM - Health Improvement Program
NAL – Nurse Advice Line

d.___ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).

e.___ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery Systems

1. **Delivery Systems**. The State will be using the following systems to deliver services:

a.___ **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b.___ **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

___ The PIHP is paid on a risk basis.
___ The PIHP is paid on a non-risk basis.

c.___ **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

___The PAHP is paid on a risk basis.

___The PAHP is paid on a non-risk basis.

d._X_ **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP. EPCCM Services will be provided by licensed nurses and health coaches under the supervision and direction of Passport Providers who are physicians, physician's assistants and nurse practitioners.

e._X_ **Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
_X_ the same as stipulated in the state plan

The Nurse Advice Line (NAL) is Fee- for-Service
___ is different than stipulated in the state plan (please describe)

f. X **Other:** (Please provide a brief narrative description of the model.)

Passport to Health

Passport to Health is Montana Medicaid's PCCM program. With Passport, Medicaid clients who are eligible, choose a Primary Care Provider to see anytime they are sick, hurt, or need preventative, primary care. The Passport Program establishes a medical home for Medicaid clients and encourages a strong and continuous patient-provider relationship. Providers sign a Passport agreement in which they consent to: provide primary care, treatment of illness or injury and preventative care services to their Passport clients; educate clients about self-referrals and appropriate use of emergency services; provide direction for emergency care 24/7; maintain a unified patient record; and provide medically necessary, appropriate referrals for any services they cannot provide. For these additional services to Passport clients, providers are given a PMPM fee for each client on their Passport caseload. Clients also receive outreach materials from the state which include information about well-child exams, seasonal materials (e.g. flu) and immunization schedules.

With Passport, most specialty services require a referral from the PCP. Passport providers are assigned a unique referral number. When a provider refers a client for a specialty service who is on their Passport caseload, they relay their Passport number to the specialty provider. The Passport referral number must be present on the claim or the claim will deny. This ensures referrals are made by providers and they are aware of the services their Passport clients are receiving.

Health Improvement Program

In 2009, Montana designed a new statewide Health Improvement Program (HIP) as an enhancement to Passport to Health. This enhanced PCCM will be operated through a network of Passport providers who will receive an enhanced case management fee to work with Passport eligible clients who have been identified as high risk, high cost through predictive modeling, or have been referred by a primary care provider. In addition to location, coordination and monitoring of primary health care services, enhanced services include the following:

- *Conduct patient health assessment within 30 days of State referral of patient to Provider, using an approved Health Survey. Patients who cannot be reached or who prefer not to participate in an assessment initially are placed in "on demand" status and additional contact attempts are made at least twice during the following 12 months.*

- *Provide initial and ongoing clinical assessment at pre-determined intervals such as 30, 60, 90 days and one year, depending on diseases and risks.*
- *Tailor a holistic treatment/action plan for each enrolled patient in consultation with patient's primary care provider.*
- *Manage patients as indicated—in person, telephonically, or other means suited to the individual.*
- *Provide group appointments for education and prevention when appropriate.*
- *Monitor and remind patients about routine testing; provide follow-up education regarding tests.*
- *Coordinate services with existing partners and form new partnerships (examples—hospitals, community primary care providers, specialists, social service and non-profit programs).*
- *Participate in multi-disciplinary hospital pre-discharge planning and counseling.*
- *Provide post hospital discharge visits, in-person and/or telephonic.*
- *Educate and support patients in self-management of health conditions.*
- *Be familiar with and refer patients to available local resources that can help patients with social services, housing, and other life problems that could prevent patients from paying attention to medical conditions.*
- *Track patient data—enrollment status, diseases, risks, interventions, and outcomes—and report to the State.*
- *In conjunction with the State, incorporate new methods such as remote disease monitoring or virtual video visits as technology is available and appropriate.*
- *Monitor patient progress and determine criteria for completion/graduation.*

See Attachment B: HIP Provider Agreement

Nurse First

Nurse First is a Nurse Advice Line service offered free of charge to Montana Medicaid Clients. Clients can call 24/7 to be triaged by a registered nurse for illness or injury or ask general health questions. When a client calls who is enrolled in Passport to Health, their PCP is faxed a triage summary of the call from Nurse First. Nurse First is a FFS program.

2. **Procurement**. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

   _X_ **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience) **For**

Network of Enhanced Primary Care Case Managers (PCCM) and Nurse Advice Line (NAL)

___ **Open** cooperative procurement process (in which any qualifying contractor may participate)

___ **Sole source** procurement

_X_ **Other** (please describe)

The current enrollment broker contract for the PCCM program is held by ACS. They were not awarded this contract through traditional means. PSI was awarded this contract in March of 2006 and requested to be released from the contract effective June 30th, 2009 due to inability to perform the work required. ACS obtained the contract through an amendment to their current MMIS contract with the State of Montana. This process was approved by CMS and state legal staff.

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. **Assurances.**

___ The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

_X_ The State is requesting a waiver of 1902(a)(4) to permit the State to mandate beneficiaries into a single PIHP/PAHP/PCCM.

The Enhanced PCCM and Nurse First programs are voluntary.

Nurse First

Montana Medicaid's Nurse Advice Line is a valuable medical benefit which all eligible clients can access, however it is not mandatory. The potential for improved health outcomes and cost savings exists when clients are better informed about their symptoms, how to treat them, they understand their health condition(s) and only utilize services when medically necessary. This service is provided by one contractor because we have one 24-hour, seven day a week, statewide toll-free telephone number for all Medicaid eligible clients to access.

Health Improvement Program

Enhanced Primary Care Case Management provides additional services including health assessment, care planning, self management education, health coaching, health status monitoring and hospital pre-discharge planning for Passport eligible clients who are identified as high cost/high risk. Passport eligible clients will be enrolled, but will have the ability to opt out. The goal of

the program is to improve health outcomes for clients and reduce costs due to unnecessary medical service utilization.

2. **Details**. The State will provide enrollees with the following choices (please replicate for each program in waiver):

___ Two or more MCOs
_X_ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
_X_ Other: (please describe)
There is one provider for Nurse Advice Line.

3. **Rural Exception.**

___ The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. **1915(b)(4) Selective Contracting**

_X_ Beneficiaries will be limited to a single provider in their service area (please define service area).
For Nurse Advice Line, statewide coverage
EPCCM, statewide coverage
See Attachment C: HIP Coverage Map and Provider County Listing

_X_ Beneficiaries will be given a choice of providers in their service area.
For the PCCM program only

D. Geographic Areas Served by the Waiver

1. **General**. Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

_X_ **Statewide** -- -- all counties, zip codes, or regions of the State have managed care (Please list in the table below)

__ **Less than Statewide**

2. **Details**. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity
Statewide	*PCCM/EPCCM*	Passport
Statewide	*FFS NAL*	Nurse First

E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations**. The Nurse Advice Line service is for all Medicaid eligible clients and the service is statewide. The following populations are included in the Waiver Program: for PCCM and EPCCM

_X_ **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

_X_ Mandatory enrollment
___ Voluntary enrollment

_X_ **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

_X_ Mandatory enrollment
___ Voluntary enrollment

_X_ **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

_X_ Mandatory enrollment
___ Voluntary enrollment

_X_ **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

_X_ Mandatory enrollment
___ Voluntary enrollment

_X_ **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

_X_ Mandatory enrollment
___ Voluntary enrollment

___ **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

___ Mandatory enrollment
___ Voluntary enrollment

_X_ **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

_X_ Mandatory enrollment
___ Voluntary enrollment

2. **Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

_X_ **Medicare Dual Eligible--**Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

___ **Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

_X_ **Other Insurance--**Medicaid beneficiaries who have other health insurance *may* be exempted from Passport. In order to receive an exemption, the clients TPL must have a managed care program that interferes with the PCCM program. These clients must apply for an exemption with ACS or the State.

_X_ **Reside in Nursing Facility or ICF/MR--**Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

___ **Enrolled in Another Managed Care Program--**Medicaid beneficiaries who are enrolled in another Medicaid managed care program

_X_ **Eligibility Less Than 3 Months--**Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program. (These clients are excluded from the Passport program but included in the Nurse First programs.)

_X_ **Participate in HCBS Waiver**--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver). These clients are excluded from the Passport program but included in the Nurse First programs.

___ **American Indian/Alaskan Native**--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

___ **Special Needs Children (State Defined)**--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

___ **SCHIP Title XXI Children** – Medicaid beneficiaries who receive services through the SCHIP program.

_X_ **Retroactive Eligibility** – Medicaid beneficiaries for the period of retroactive eligibility.

Other (Please define):

_X_ *Medically needy clients with a spend down. These clients are included in the Nurse First program but are excluded from Passport unless they are part of Team Care. The system will have a separate program indicator for the Passport and Team Care programs. A medically needy client with a Team Care indicator will ensure the client's participation in the Team Care program. A client's medically needy status will be transferred to the contractor through the eligibility file received from CHIMES (state Medicaid eligibility system)*

___ Clients living in an area without Medicaid managed care.

_X_ Clients in a Medicaid eligibility subgroup of Subsidized Adoption

_X_ *Clients who cannot find a PCP who is willing to provide case management. These clients are included in the Nurse First program but are excluded from Passport unless they are part of Team Care.*

_X_ *Clients who reside in a county in which there are not enough primary care providers to serve the Medicaid population. These clients are included in the Nurse First and Enhanced PCCM programs but may be excluded from Passport unless they are part of Team Care.*

F. Services

List all services to be offered under the Waiver in Appendices D2.S and D2.A of Section D, Cost-Effectiveness.

1. **Assurances.**

_X_ The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM. The Provider Agreement for the Enhanced PCCM will be submitted to CMS for approval.

_X_ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

_X_ The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

_X_ The PAHP, PIHP, or FFS Selective Contracting program does not cover emergency services.

3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

___ The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services

___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers

___ The State will pay for all family planning services, whether provided by network or out-of-network providers.

_X_ Other (please explain): The State will pay for covered family planning services furnished by enrolled Medicaid providers.

___ Family planning services are not included under the waiver.

4. **FQHC Services**. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

_X_ The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

Enrollees can select any PCP in the state including any of the FQHC's that are enrolled as Passport providers.

___The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

5. **EPSDT Requirements.**

_X_ The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. **1915(b)(3) Services.**

___This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

7. **Self-referrals.**

_X_ The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Passport Clients can self-refer to any Montana Medicaid provider for the following services:

- *Ambulance*
- *Anesthesiology*
- *Blood lead testing*
- *Christian science nurses & sanatoriums (EPSDT)*
- *Dental (except orthodontia & dental surgery)*
- *Dialysis*
- *Dialysis Attendant*
- *Drug/Alcohol outpatient treatment (EPSDT)*
- *Durable medical equipment*
- *Emergency Services*
  - *Emergency room screening*
  - *Emergency room services for emergent conditions*
- *Eye exams*
- *Eyeglasses*
- *Family planning*
- *Hearing aids*
- *Hearing exams*
- *Home & Community Based Waiver services*
- *Home care*
- *Home infusion therapy*
- *Hospice*
- *Hospital-nursing home care beds*
- *Immunizations*
- *Indian Health Service Clinic*
- *Lab*
- *Mental health services*
  - *Community mental health centers*
  - *Inpatient & outpatient with specific diagnosis*
  - *Inpatient hospital psych*
  - *Licensed professional counselors*
  - *Licensed social worker services*
  - *Other psych practitioner*
- *Nursing home and ICFMR services*
- *Obstetrical services*
- *Ophthalmology services*
- *Optometry services*
- *Personal care attendant services*
- *Pregnancy-related services*
- *Prescription drugs*
- *Prosthetic devices*
- *Residential treatment centers*
- *Skilled & intermediate nursing services in nursing facilities*

ICF-MR services
Swing bed services

- *STD (Sexually Transmitted Diseases)*
  Testing & treatment
  Department designated sites
- *Substance Abuse services*
- *Targeted Case Management*
- *Transportation*
- *X-ray services*

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. **Assurances for MCO, PIHP, or PAHP programs.**

_X_ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

2. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

a._X_ **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1._X_ PCPs (please describe):

Montana is a rural, frontier state characterized in the east by sparsely populated plains and in the west by small clusters of populations separated by mountain ranges. Given the diversity in geography and population density, Montana does not use a single distance and/or travel time to gauge access. Instead, we determine through a variety of means, like client surveys, whether Passport primary care providers are available in the normal service delivery area for each town or region. In a frontier state like Montana, this case-by-case approach is more meaningful to clients who are accustomed to living, and often choose to live, extended distances from services.

2. X Specialists (please describe): *Passport clients can, with a referral from his/her PCP, go to any Montana Medicaid provider.*

3. X Ancillary providers (please describe your standard):
Passport clients can, with a referral from his/her PCP, go to any Montana Medicaid provider.

4. X Dental (please describe): *Passport clients can go to any Montana Medicaid provider without a referral.*

5. X Hospitals (please describe your standard):
Passport clients can, with a referral from his/her PCP, go to any Montana Medicaid provider.

6. X Mental Health (please describe your standard):
Mental Health services do not require a referral from a client's primary care provider. Passport clients can self refer to Montana Medicaid mental health providers.

7. X Pharmacies (please describe your standard):
Passport clients can go to any Montana Medicaid provider. Team Care clients are locked into one pharmacy. The pharmacy restriction can be lifted temporarily by State staff or the enrollment broker if need be.

8. X Substance Abuse Treatment Providers (please describe your standard):
Substance Abuse Treatment services do not require a referral from a client's primary care provider. Passport clients can self refer to Montana Medicaid mental health or substance abuse providers.

9. X other providers (please describe):
Passport clients can, with a referral from his/her PCP, go to any Montana Medicaid provider.

b. X **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. X PCPs (please describe):
For both PCPs and other providers we have adopted the standards adopted by the state for HMOs.
    1. *Emergency services must be available and accessible at all times.*
    2. *Urgent care appointments must be available within 24 hours.*
    3. *Appointments for non-urgent care with symptoms must be available within 10 calendar days.*
    4. *Appointments for routine or preventive care must be available within 45 calendar days.*

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7. X Urgent care (please describe):
Urgent care appointments must be available within 24 hours.

8.___ Other providers (please describe):

c. X In-**Office Waiting Times**: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. X PCPs (please describe):
    i.___ Capitated Program (please describe your standard):

    ii. X PCCM Program (please describe your standard):
    We have not established standards for in-office wait times; however, we do monitor this for any problems through the Client Help Line and client surveys.

2.___ Specialists (please describe):

3.___ Ancillary providers (please describe):

4.___ Dental (please describe):

5.___ Mental Health (please describe):

6.___ Substance Abuse Treatment Providers (please describe):

7.___ other providers

i.___ Capitated Program:

ii._X_ PCCM Program (please describe your standard):
We have not established standards for in-office wait times; however, we do monitor this for any problems through the client help line and client surveys.

d. ___ Other **Access Standards** (please describe)

3. **Details for 1915(b)(4) FFS selective contracting programs:**
Please describe how the State assures timely access to the services covered under the selective contracting program.

Nurse First

The Nurse Advice Line vendor's staff schedule is dictated by their call volume. Nurse Response utilizes a work force management (WFM) system called Blue Pumpkin. Nurse Response has a dedicated WFM department, their primary responsibility is to; forecast call volumes, complete scheduling, report, monitor real time metrics and service levels, and assist with any type of outage. The WFM system allows you to forecast with appropriate service levels and populate a schedule based on the requirements.

In order to ensure enough customer service representatives (CSRs) and RNs are available to handle the inbound and outbound call queues, the WFM team creates a forecast based on historical call trends and adjusts for any new clients, current trends, etc. Once the forecast has been created the WFM department breaks the time down to 30 minute intervals and runs the call volumes through an Erlang C calculator to see how many RNs are required per 30 minute interval in order to reach performance goals. The WFM department verifies requirements versus schedule to ensure adequate coverage. The WFM department continually monitors their coverage requirements 24/7/365 on a real time basis with the WFM team and frontline management team.

The WFM Department and Telecom group work together to review call trunk space (available inbound/outbound lines) to ensure ample trunk space is available to allow all calls without experiencing any type of blockage (blockage indicates that you need to review trunk spacing). The vendor reviews this monthly as well as quarterly and looks ahead to any additional services they may be offering. Should they come near to capacity, Nurse Response has a plan in place that includes a disaster recovery overflow

switch which can be utilized until new circuits have been installed to increase current trunk space. This tool has never been needed but it is available should the situation occur.

During September, 2009 the NAL received 475 calls. The average hold time was 36 seconds. The average length of call was 264 seconds, with an average talk time of 214 seconds. Abandoned calls numbered 34, or 7.2%.

B. Capacity Standards

1. Assurances for MCO, PIHP, or PAHP programs.

_X_ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. _X_ *The State has set enrollment limits for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.*

The State allows a limit of 1000 clients per PCP. Each provider can select his/her own limit not to exceed 1000 clients. The enrollment system has a lock in place to disallow the enrollment for any provider to exceed his/her preselected limit. Once that limit has been reached clients can be enrolled with a provider on a pending basis. This pending status allows the provider to choose whether to accept the client. If the client calls in to select the provider and the provider has reached the selected limit the client is informed of the "pending"

status. If the provider does not choose to accept the increased caseload the client is sent a letter telling him/her to select another provider. If the limit has been reached, no one can be auto-assigned to that provider.

A client not currently enrolled who chooses a "pending" or "limited" provider is not required to get a referral for services until the client is actively enrolled with a provider. Therefore, the client is able to access all Medicaid covered services while on the "pending list"

If a client currently enrolled with a provider in the Passport program and decides to change to a provider who is "limited", the client remains with the current provider through the end of the current month. At the beginning of the following month, the client would not be actively enrolled with a provider, therefore, would not be required to get a referral for Medicaid covered services. The client would have access to all Medicaid covered services until they are actively enrolled again with another provider. There are no clients who do not have access to a provider.

Caseload limits are monitored periodically by running a report of providers, their limits and the number of clients on their caseload. Providers are sent letters or called to ask about increasing the selected limits. If it is noted that a provider has reached his/her limit and is having several clients requesting him/her as PCP, a letter or phone call is made asking the provider to increase the selected limit.

b. X The State ensures that there are adequate number of PCCM PCPs with open panels. Please describe the State's standard.

The State monitors potential provider access issues every six months with our network adequacy report. There have been no issues with access to PCPs in the State. The State reviews limited provider's pending lists semi annually to ensure that requesting clients are being notified of decisions regarding their choice of providers.

c. X The State ensures that there is an adequate number of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State's standard for adequate PCP capacity.

The State reviews the network adequacy report semi annually to ensure all participating counties have an adequate number of PCPs to ensure access to Medicaid clients. To date there have been no issues concerning access in the state.

d. X The State compares numbers of providers before and during the Waiver. Please modify the chart below to reflect your State's PCCM program and complete the following.

	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians		96	96
Family Practitioners		292	292
Internists		159	159
General Practitioners		79	79
OB/GYN and GYN		31	31
FQHCs		21	21
RHCs		38	38
Nurse Practitioners		154	154
Nurse Midwives		11	11
Indian Health Service Clinics		10	10
Additional Types of Provider to be in PCCM			
1. Physician Assistant		121	121
2. Oncologist		1	1
3. Certified Nurse Specialist		1	1
4. General Surgery		8	8
5. Cardiovascular Disease		3	3
6. Gastroenterology		2	2
7. Nephrology		5	5
8. Neurological Surgery		3	3
9. Orthopedic Surgery		4	4
10. Pulmonary Disease		5	5
11. Rheumatology		1	1
12. Urology		1	1

*Please note any limitations to the data in the chart above here:
This listing is for the entire state. Montana's rural/frontier nature results in a limited number of specialists and sub-specialists throughout the state.

e. X The State ensures adequate geographic distribution of PCCMs. Please explain.

The state attempts to outreach and bring on all potential Passport Providers, focusing efforts in areas where we see the greatest need. The quarterly Network Adequacy report lists all counties and the ratios of providers to clients. No geographic areas have adequate distribution. Montana is a frontier state with limited providers. This limitation is not unique to Passport/Medicaid clients, but affects all Montanans.

f.___ PCP: Enrollee **Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

Area(City/County/Region)	***PCCM-to-Beneficiary Ratio***
Beaverhead	*1 :25*
Big Horn	*1:672*
Blaine	*1:180*
Broadwater	*1:75*
Carbon	*1:35*
Carter	*1:9*
Cascade	*1:46*
Choteau	*1:17*
Custer	*1:34*
Daniels	*1:12*
Dawson	*1:27*
Deer Lodge	*1:53*
Fallon	*1:13*
Fergus	*1:41*
Flathead	*1:51*
Gallatin	*1:24*
Garfield	*1:16*
Glacier	*1:164*
Golden Valley	*0:35*
Granite	*1:43*
Hill	*1:60*
Jefferson	*1:86*
Judith Basin	*1:23*
Lake	*1:108*
Lewis & Clark	*1:48*
Liberty	*1:43*
Lincoln	*1:66*
Madison	*1:10*
McCone	*1:0*

Meagher	*1:21*
Mineral	*1:47*
Missoula	*1:49*
Musselshell	*1:38*
Park	*1:28*
Petroleum	*0:2*
Phillips	*1:114*
Pondera	*1:85*
Powder River	*1:30*
Powell	*1:39*
Prairie	*1:29*
Ravalli	*1:60*
Richland	*1:21*
Roosevelt	*1:159*
Rosebud	*1:87*
Sanders	*1:38*
Sheridan	*1:136*
Silver Bow	*1:61*
Stillwater	*1:129*
Sweet Grass	*1:63*
Teton	*1:18*
Toole	*1:24*
Treasure	*1:18*
Valley	*1:40*
Wheatland	*1:19*
Wibaux	*0:12*
Yellowstone	*1:39*
Statewide Average	*1:60*

g. ___ **Other capacity standards** (please describe):

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

Nurse First

The Nurse Advice Line vendor's staff schedule is dictated by their call volume. Nurse Response utilizes a work force management (WFM) system called Blue Pumpkin. Nurse Response has a dedicated WFM department, their primary responsibility is to; forecast call volumes, complete scheduling, report, monitor real time metrics and service levels,

and assist with any type of outage. The WFM system allows you to forecast with appropriate service levels and populate a schedule based on the requirements.

In order to ensure enough customer service representatives (CSRs) and RNs are available to handle the inbound and outbound call queues, the WFM team creates a forecast based on historical call trends and adjusts for any new clients, current trends, etc. Once the forecast has been created the WFM department breaks the time down to 30 minute intervals and runs the call volumes through an Erlang C calculator to see how many RNs are required per 30 minute interval in order to reach performance goals. The WFM department verifies requirements versus schedule to ensure adequate coverage. The WFM department continually monitors their coverage requirements 24/7/365 on a real time basis with the WFM team and frontline management team.

The WFM Department and Telecom group work together to review call trunk space (available inbound/outbound lines) to ensure ample trunk space is available to allow all calls without experiencing any type of blockage (blockage indicates that you need to review trunk spacing). The vendor reviews this monthly as well as quarterly and looks ahead to any additional services they may be offering. Should they come near to capacity, Nurse Response has a plan in place that includes a disaster recovery overflow switch which can be utilized until new circuits have been installed to increase current trunk space. This tool has never been needed but it is available should the situation occur.

During September, 2009 the NAL received 475 calls. The average hold time was 36 seconds. The average length of call was 264 seconds, with an average talk time of 214 seconds. Abandoned calls numbered 34, or 7.2%.

C. Coordination and Continuity of Care Standards

1. **<u>Assurances For MCO, PIHP, or PAHP programs</u>.**

___ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

2. **Details on MCO/PIHP/PAHP enrollees with special health care needs**.

The following items are required.

a. ___ The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

b. ___ **Identification**. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

c. ___ **Assessment**. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

d. ___ **Treatment Plans**. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1.__ Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee

2.__ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3.__ In accord with any applicable State quality assurance and utilization review standards.

e. ___ **Direct access to specialists**. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

a. X Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.

b. ___ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.

c. X Each enrollee is provided health education/promotion information. Please explain.

Passport to Health
Clients receive information about the Passport Program from the Medicaid Helpline, the Welcome to Passport mailing and an online tutorial. This includes information about the importance of health maintenance and having a medical home.

In the month proceeding a child's birthday, parents are sent a letter reminding them that Medicaid covers well-child visits and dental visits. They are also sent an age-appropriate immunization schedule magnet.

Passport clients are encouraged to use Nurse First. They learn about Nurse First through mailings and audio postcards. Clients can call Nurse First 24 hours a day, seven days a week, to ask general health questions or be triaged for illness or injury. Nurse First offers online tools including home-health information and a decision support tool.
See Attachment D: Health Education/ Promotion Information

Health Improvement Program
Enrollees in the EPCCM will receive education and healthcare information from their Nurse Case Manager, Health Coach or PCP that is specific to their health status, current medical condition and/or identified as a need in their treatment plan. They will be given this information directly by health center staff, will have access to the Nurse Advice Line's Audio Health Library, Healthwise website and can be mailed directly to the client.

d. X Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.

e. X There is appropriate and confidential **exchange of information** among providers.

f. X Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
It is expected that as part of the healthcare delivered by the PCP the client is informed of his/her health condition, follow-up and is given any training necessary. Although this is not specifically stated in our contract, it is part of providing healthcare.

g. X Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
See f. above

h. X **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).

Passport providers are contracted to provide case management of his/her client's care. Clients are referred by their PCPs for medical services that the primary care provider determines are necessary but cannot provide directly. The primary care provider is required to document all referrals in the client's record or in a log book. The referral to the specialist or treating provider can be verbal or written.
The Passport EPCCM program provides additional services by care managers including patient assessment, development of care plan, health monitoring, coordinating care, pre and post hospital stay planning and health education.

i. X **Referrals**: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

Referrals are either verbal or written. We do not require that the primary care provider complete a written referral form. The primary care provider, must however, document the referral into the client's medical record or a log book. It is expected, as standard healthcare practices, that the referred to provider will notify the PCP of the results of any referral.

4. **Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

The Nurse Advice Line faxes the client's primary care provider a triage/disposition report. This fax allows the PCP to know when their client called the NAL, what symptoms they presented, the Nurse's recommendations (i.e. seek ER immediately, call PCP and make appointment or self care) and can become a part of their client's medical record. This service allows for care coordination and continuity of services.

Section A: Program Description

Part III: Quality

1. **<u>Assurances for MCO or PIHP programs</u>**.

___ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on _____.

___ The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP				

2. **Assurances For PAHP program.**

__ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for PCCM program**. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. X The State has developed a set of overall quality **improvement guidelines** for its PCCM and EPCCM programs. Please attach.
We continued to monitor quality of services through the following means:

- *Access and Adequacy – Network Adequacy Report, Provider Type Listing Report, Client Survey, Complaints, Fair Hearing Requests, 24-Hour Call Log Report, Provider Change Report, Change Enrollment Report. For details on the results of this monitoring see Section B.*

- *In the previous waiver document we monitored Client Satisfaction -This is monitored indirectly through the Provider Change Report and Change Enrollment Report. It is monitored directly through the following means:*

    - *Client mail survey –We will conduct a statistically valid survey at an 85% confidence level with a margin of error of 5%. While one of our goals is to have a consistent survey that we can compare from year to year, we continue to make modifications to our survey to ensure the questions are formatted appropriately so they do not confuse the clients, and to ensure that we ask questions that are beneficial to our monitoring of the program.*
    - *Complaint and Grievance – Clients are made aware of the complaint and grievance process and their right to a fair hearing in the Medicaid Client Handbook. For provider or program*

specific complaints, clients are directed to call the client helpline operated by our enrollment broker. The enrollment broker records the complaint and explains the process to the client. The client is sent a letter describing the details of the complaint as it was received by the helpline. The client is asked to sign the letter and send it back to the helpline to confirm the information is correct. If it is incorrect, the client is asked to correct the information or call the helpline to relay the correct information. When a signed, correct complaint is received by our enrollment broker, it is forwarded to a state program officer who is designated to receive all complaints. The program officer records the complaint in a shared, password protected spreadsheet. The complaint is then forwarded to the appropriate program officer who investigates the matter. Investigation may include contacting the client, contacting a provider, researching the ARM or MCA, looking at claims, etc. A letter is sent to the client and sometimes the provider explaining the results of the investigation, any action taken by the state and any action required on the part of the client and or provider. Copies of letters and investigatory materials are forwarded to the program officer who is responsible for receiving all complaints and the spreadsheet is updated with findings. The client and provider are encouraged to follow-up if they have questions or concerns about the findings. If the findings are not in favor of the provider or client and they wish to pursue the matter further, they are informed about the fair hearings process.

- *Comprehensive Overview Report of QA Activity - This comprehensive report will be provided quarterly and looks at all QA activity. To date, we have not found population-wide issues, region-wide issues, quality of care issues or issues specific to one provider.*

b. X **State Intervention**: If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1. X Provide education and informal mailings to beneficiaries and PCCMs;

2. X Initiate telephone and/or mail inquiries and follow-up;

3. X Request PCCMs response to identified problems;

4. X Refer to program staff for further investigation;

5. X Send warning letters to PCCMs;

6. X Refer to State's medical staff for investigation;

7. X Institute corrective action plans and follow-up;

8. X Change an enrollee's PCCM;

9. X Institute a restriction on the types of enrollees;

10. X Further limit the number of assignments;

11. X Ban new assignments;

12. X Transfer some or all assignments to different PCCMs;

13. X Suspend or terminate PCCM agreement;

14. X Suspend or terminate as Medicaid providers; and

15. X Other (explain):

When a complaint regarding access or quality of care is identified, a provider's records may be requested and reviewed by the State. If an issue is due to lack of knowledge regarding rules and regulations on the part of a provider, the provider is made aware of their error. Education and follow-up for the PCP and client is provided. If a definite quality of care issues arises, the case is referred to a panel of physicians, under consultation. The physician's panel is given the complete case file and asked to review the information. The case is peer reviewed and scored accordingly. The provider and/or client involved are informed of the process and outcome. The case is followed for a period of time to be determined by the physicians' panel. Each case is assessed individually and documentation is maintained and updated as needed. During the current waiver period there have been no problems referred to a physician's panel.

c. X **Selection and Retention of Providers**: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

   A. ___ Initial credentialing

   B. ___ Performance measures, including those obtained through the following (check all that apply):

      ___ The utilization management system.
      ___ The complaint and appeals system.
      ___ Enrollee surveys.
      ___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___ notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. _X_ Other (please describe).

   Our enrollment broker, ACS, performs outreach to potential Passport Providers and helps them to complete paperwork necessary for enrollment.
   Montana Medicaid providers are eligible to be Passport Providers if they are a physician, mid-level, nurse practitioner, physician's assistant or a specialist who provides primary care to Passport clients and additionally agrees to:

   - *Offer suitable coverage during normal office hours.*
   - *Give direction to clients for emergent care 24/7.*
   - *Offer comprehensive medical services including preventative care.*
   - *Follow protocol for enrollment and disenrollment of clients*

- *Agree to provisions in the Passport Agreement and the Passport Provider Handbook.*
- *Provide case management services in accordance with the agreement.*
- *Maintain a unified patient record for each Passport client.*
- *Document clients' referrals.*

See Attachment E: Passport Provider Handbook

d. ___ **Other quality standards** (please describe):

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

Passport to Health, Nurse First and Health Improvement Programs are not marketed to enrollees or potential enrollees.

1. **Assurances**

_X_ The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

_____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details

a. Scope **of Marketing**

1._X_ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.

2.___ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

3.___ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

b. Description. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1.___ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

2.___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3.___ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):

i.__ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.

ii.__ The languages comprise all languages in the service area spoken by approximately ___ percent or more of the population.

iii.__ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. **<u>Assurances</u>.**

_X_ The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the

waiver will apply, and what the State proposes as an alternative requirement, if any.

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. <u>Details</u>

a. Non-English Languages

_X_ Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

The State has no need to translate materials because we have no prevalent languages other than English. Montana has very few non-English speaking groups, none of which comprise 10 percent of the population. We are prepared to translate materials if there is a need. To date we have emailed one blind participant the Medicaid General Handbook so he could listen to the handbook through his computer.

The State defines prevalent non-English languages as:
(check any that apply):

1.__ the languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."
2. _X_ the languages spoken by approximately _10_ percent or more of the potential enrollee/ enrollee population.
3.__ other (please explain):

_X_ Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

Translators are available at no charge to clients who need translator services during the eligibility determination process or during the receipt of medical services.

_X_ The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

Enrollees or potential enrollees can access translators (including sign-language) to assist them in communicating in order to understand the program. Providers, eligibility specialists and our enrollment broker and state staff can access translator services in order to explain the program to non-English speaking clients. Because Montana has no prevalent languages other than English, and we have had no requests to date, we have not translated any written materials.

b. **Potential Enrollee Information**

Information is distributed to potential enrollees by:

_X_ State
_X_ Contractor (please specify)

Passport to Health

The enrollment process for Passport starts with Medicaid eligibility conducted at the local County Offices of Public Assistance (OPA). Medicaid information and basic Passport information is given to all potentially eligible clients. The information is given verbally by the Eligibility Case Manager and in the form of the General Medicaid Handbook.

Clients receive a letter from the OPA when Medicaid eligibility is determined. The data for Medicaid eligible clients who have also been determined Passport eligible is then sent to our enrollment broker (ACS).

Health Improvement Program

For the EPCCM, all eligible clients will be notified of enrollment at the same time as they are notified of their Passport to Health enrollment. The health centers will make direct contact with those members selected through predictive modeling for case management. They will contact these clients initially by letter followed by up to three telephone attempts. If they are not able to reach by telephone, a follow-up letter will be sent. Patients will be given all of the information about the program both in writing and by telephone when contacted by the health centers.

Nurse First

Nurse First clients are notified of their eligibility for the program through the OPA office, the general Medicaid Handbook and the Passport outreach calls.

___ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

(i) _X_ the State
(ii) _X_ State contractor (please specify): See (b.) above
(ii) _X_ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

_X_ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. **Details**. Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. _X_ **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

General Medicaid Outreach

The Medicaid Outreach Program works with partners around the state of Montana to bring awareness of the benefits of Medicaid to the general public, to persons potentially eligible and to current recipients.

The main outreach focus has been targeted outreach efforts that develop partnerships with organizations that have regular, face-to-face working relationships with low-income Montanans. To that end, the State has developed productive working relationships with hundreds of partners including food banks, schools, Indian tribes, community health centers, Head Starts, advocacy groups, county health departments, clinics, hospitals and more. The Medicaid Outreach Coordinator gives presentations to partners around the state on a regular basis. The coordinator develops and distributes materials to partners that describe Medicaid and its benefits, including managed care services, and provides information on how to enroll.

Increasingly, outreach efforts have emphasized the Medicaid managed care programs: Passport to Health, Team Care and Health Improvement. Managed care program officers and the outreach coordinator have organized presentations at clinics, tribal health facilities and community health centers. Building good working relationships with providers facilitates a broader utilization of benefits by clients. We have made a particular effort to involve the participation of Indian tribes in the enrollment of eligible tribal members and the provision of Medicaid managed care services. Our efforts have been part of a broader state government commitment to foster better government to government relationships with Montana's Indian nations.

See Attachment F: General Medicaid Outreach Materials

Passport to Health

Our enrollment broker (ACS) markets the program with outreach materials and calls. When a client is deemed Passport eligible, our EB sends a Welcome to Passport packet. This packet includes: a letter explaining the Passport Program; information on how to enroll with a provider by phone, post or on the web. The packet also includes a list of ten PCPs clients can choose from (clients are told they can choose a PCP who is not on the list as long as the PCP is a Passport Provider). The first provider on the list is the provider the client will be assigned to if they do not choose a provider. This provider is system generated using an algorithm which looks at (in the order listed) the clients previous Passport enrollment, family enrollment, claims history, Tribal enrollment (if tribally enrolled the provider will be IHS) and geographic area. The other nine providers on the list are the closest within a fifty mile radius of the client address. After a client has received outreach materials by mail, over 80% will receive an outreach call. During the call, program is explained in detail and the client is given an opportunity to ask questions and choose a provider over the phone. If a client has not enrolled with a PCP 30 days after they were sent the initial outreach materials, they will receive a final letter encouraging them to voluntarily enroll with a provider, or have one chosen for them.

The outreach performance standard for ACS is to successfully outreach 80 percent of those clients new to Passport with telephones. This goal is always met

and most months exceeded. Please see the Client Outreach Enrollment Process chart on page 54.

Children enrolled in Passport to Health receive a letter (from ACS) in the month proceeding their birthday reminding their parents that Medicaid pays for Well-Child check-ups, and explaining what the exams entail. Each family also receives an immunization schedule magnet.

Passport Program staff participate in bi-annual provider trainings throughout the state in conjunction with ACS. We also coordinate trainings for specific providers or groups as necessary. Program staff regularly writes articles with Passport updates for the Claim Jumper, the ACS provider newsletter. We regularly update print and web-based client and provider information.

See Attachment D: Health Education/ Promotional Materials
Attachment G: Passport Outreach Materials

Team Care

Clients enrolled in Team Care receive a letter of explanation and a 345-page self-care guide. Drug Utilization Review (DUR) case managers in the Medicaid Pharmacy Program speak with PCPs and pharmacies about individual clients who may be appropriate for Team Care.

See Attachment H: Team Care Outreach Materials

Health Improvement Program

The network of Passport Providers who will provide enhanced PCCM services will make a minimum of five attempts (2 in writing and three via telephone) to engage members recommended by the State. They will also follow-up with any clients they are not able to reach at six-month intervals.

Nurse First

The Nurse First program is explained in the client handbooks, and all Passport brochures.

Client Outreach / Enrollment Process	
Day 1	*Receive client file from County (**CHIMES**).*
Day 1-2	*Send Client Welcome Letter and Enrollment Packet.*
Day 5-10	*1st Outreach/Enrollment Call or Attempt.*
Day 10-15	*2nd Outreach/Enrollment Call or Attempt.*
Day 15	*Send Client Reminder Letter if not yet enrolled.*
Day 16-30	*3rd Outreach/Enrollment Call or Attempt.*
Day 30	*Mail the Intent to Default or Automatic Assign Letter. (This event occurs once per month on the 11th or next business day of the month.)*
Day 30 - 40	*Outreach/Enrollment Call or Attempt to clients that have been assigned.*

Day 40	*Enrollments uploaded to MMIS. (Cutoff Day)*
Day 47-48	*Beginning of next month - Enrollments take effect on the 1st of the new month.*

**Note: In order to ensure that persons have sufficient time to choose a provider and voluntarily enroll with that provider, ACS allows a minimum of 30 days from the time a person is deemed eligible for managed care before assignment. The monthly "cut-off date" occurs around the 23rd of every month. If a client has been on managed care two months in the past, the individual is reinstated with their previous PCP.*

b. Administration of Enrollment Process.

___ State staff conducts the enrollment process.

_X_ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

_X_ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: *ACS*

Please list the functions that the contractor will perform:

_X_ choice counseling
_X_ enrollment
_X_ other (please describe):

Other: *The contractor's duties include maintaining the Medicaid Help Line. Clients may call the Medicaid Help Line for questions unrelated to Passport. The contractor's duties include providing general Medicaid information and phone referrals to other entities when necessary. Also included in the enrollment function is exemption processing.*

_X_ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

For the enhanced PCCM, the Care Managers of the Network of Passport Providers will conduct outreach for those clients identified. This involves an initial letter explaining the program, providing contact information and giving instructions for opting out of the program. This letter is followed by up to three telephone calls and a follow-up letter. Additional outreach will be done at six-month intervals for those who are not reached initially.

c. **Enrollment.** The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

___ This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

__ This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

_X_ If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

i. _X_ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

Passport to Health auto-assigns clients to a provider if they have not chosen one, sixty days or more after the first outreach attempt. The auto assignment algorithm is intended to choose the best suited PCP for a client. The system assigns by the following criteria, in this order:

1. *Previous Passport enrollment*
2. *Most recent claims history*
3. *Case (family) Passport assignment(s)*
4. *Native Americans will be assigned to IHS if one is within fifty miles of their home*
5. *Geographic area (within a fifty mile radius)*

___ The State **automatically enrolls** beneficiaries

___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)

___ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)

___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

___ The State provides **guaranteed eligibility** of ____ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

_X_ The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

1. TPL (Covers most medical needs and requires the client to choose a PCP.) When a client requests a TPL exemption the TPL unit at ACS contacts the insurance company to determine whether participation in Passport would create a hardship for the client. This may be if the other insurance requires that the client stay in a network or participates in another managed care program.

2. Out of state foster care/treatment center. –not eligible auto exemption written into our MMIS system

3. Error correction/incorrect enrollment exemptions.

4. Provider leaves without 30 day notice.

5. Doctor refuses to see patient or give referrals.

6. Other ACS granted exemptions. ACS staff is able to exempt clients from Passport if enrollment in the program would cause hardship due to certain medical circumstances. Clients are directed in the general Medicaid Handbook to call the client help line if they would like an exemption due to medical need. In the cases of neonatal care or ICU, or ACS can grant a medical exemption without elevating it to the state. For all other medical hardship exemptions, ACS sends a request form to the client which is sent on to the state. ACS provides the State with a monthly exemption report and regularly revisits exemptions they have granted to ensure they are still required. (E.g. calls on neonatal every 60 days to determine if baby is still inpatient).

7. State granted medical hardship. This exemption process consists of the client or his/her agent, requesting an exemption in writing to the state. The Department reviews the exemption request. Reviews may consist of the following: review of claims, review of managed care history, phone conversations with medical providers, review of patient charts, phone conversation with client, etc. When a determination is made the client is notified via letter of the decision and notified of his or her right to appeal if the decision is negative. An exemption is granted for a period of time that accommodates the individual client and will usually be a period from 3 months to six months. A monitoring system is in place to review exemptions with the goal of ending the exemption when appropriate and enrolling the client with a PCP.

Team Care clients cannot be exempt from the program but can request a fair hearing.

The Nurse First program and EPCCM are voluntary.

_X_ The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. **Disenrollment:**

_X_ The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i._X_ Enrollee submits request to State.

The plan may approve the request, or refer it to the State.

The plan may not disapprove the request.

Clients may change providers up to once per month without cause. Providers can request that a client be disenrolled for cause. The request from the provider must be in writing and should allow 30 days for the change to take place.

If a provider requests that a client be removed from his or her caseload after the 6th working day from the end of the month, they must give care or referrals to the client through the end of the month. If the provider is unwilling we give the client an "emergency" exemption, which means the client can see any Medicaid provider that month without referral. The client's provider change information is entered into OmniTrack (call tracking software). The client is sent a letter instructing him or her to choose a new provider if the PCP initiated the change. A list of providers is enclosed with the letter. When a Passport provider leaves the Passport Program, all of his or her clients are disenrolled using the above procedure. ACS updates the provider information in the Passport database.

Team Care clients must petition the Department or ACS to make a provider change. ACS and/or the Team Care program officer will review the circumstance of the request and determine if a change is warranted. Pharmacy changes take effect the first day of the next month after cut off unless extenuating circumstances require the pharmacy change to be immediate.

Clients are enrolled in Team Care for a minimum of 24 months. Cases are assessed on an individual basis after they have met the minimum time requirement. Part of the assessment includes contacting the client's Team Care Provider. If a provider validates that a client has shown adequate improvement regarding previous misuse of the Medicaid program, the client may be graduated from the Team Care program. Most clients, however, are enrolled for a period of longer than 24 months and many have been on the Team Care program since its inception.

ii.___Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii.___Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

___ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

_X_ The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ____ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):
The states lock-in program, Team Care, is a sub-program of Passport to Health. Team Care clients are locked-in to one PCP and one pharmacy and unable to change without good cause.
Team Care clients can request a change in provider from the state if they move out of the provider's service area.

__ The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

___ The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

_X_ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

A provider may disenroll or terminate the provider-patient relationship, in accordance with the provider's professional responsibility by providing 30 days written notice to the recipient and to the Department. The provider shall continue to provide patient management services for 30 days while the disenrollment is being completed. Only in certain circumstances will an exception be made to this rule. During this time the provider may either continue to treat the recipient or refer to another provider. Passport will assist the recipient in selecting a new PCP.

A provider may disenroll a Passport client for the following reasons:

- *The provider-patient relationship is mutually unacceptable*
- *The client fails to follow prescribed treatment*
- *The client is abusive*
- *The client could be better treated by a different type of provider, and referral process is not feasible*

i. X The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

ii. X If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCMs caseload.

iii. X The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. **Assurances.**

X The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

X The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

The Montana Department of Health and Human Services employs a HIPAA privacy officer. All DPHHS and ACS employees are required to attend

HIPAA training and be evaluated on the training. The state has reviewed and will comply with the new HIPAA regulations set forth in the American Recovery and Reinvestment Act.

The HIPAA privacy officer is consulted when questions arise regarding HIPAA. The steps taken by our helpline and state staff to ensure HIPAA compliance have been approved by our HIPAA officer. The rules that affect our everyday work are:

- *PHI or identifying information is only transferred electronically through secure email or secure file transfer.*
- *Clients and providers are required to give at least three pieces of identifying information when they call the help line or state staff in order to discuss PHI or any client identifying information.*
- *PHI or identifying information is not given unless it is required.*

E. Grievance System

1. **Assurances for All Programs**. States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

_X_ The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. **Assurances For MCO or PIHP programs**. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

___ The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for

PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

__ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for MCO or PIHP programs**.

a. **Direct access to fair hearing**.

___ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

__ The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. Timeframes

___ The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is ___ days (between 20 and 90).

___ The State's timeframe within which an enrollee must file a **grievance** is __ days.

c. Special **Needs**

___ The State has special processes in place for persons with special needs. Please describe.

4. **Optional grievance systems for PCCM and PAHP programs**. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

_X_ The State has a grievance procedure for its PCCM/PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

___ The grievance procedures is operated by:

_X_ the State
_X_ the State's contractor. Please identify: ____ACS_____
___ the PCCM
___ the PAHP.

a. _X_ Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

Quality of Care (QOC) Complaint: Informal, verbal communication by a client or their authorized representative indicating that s/he wants the opportunity to present her/his case to a reviewing authority regarding what the client or her/his authorized representative perceives to be inappropriate or lack of appropriate care or services received from the state, or any of its agents or providers under the Medicaid program. QOC reasons are listed below:

- *Had to wait too long for an appointment.*
- *Provider or staff did not explain things clearly.*
- *Provider or staff was rude.*
- *Not getting good medical care.*

General Complaint: Informal, verbal or email (sent through our client website) communication by a client or their authorized representative indicating that s/he wants the opportunity to present her/his case to a reviewing authority regarding what the client or her/his authorized representative perceives to be inappropriate or lack of appropriate service related to issues regarding eligibility, satisfaction with county or state agencies, or other similar matters not related to QOC concerns.

Formal Complaint: Written communication from a client or her/his authorized representative is a follow-up to a verbal complaint. This written communication is sent by the state to the client to confirm a complaint that was given verbally.

Grievance: Written communication which a client or her/his authorized representative presents indicating s/he wants the opportunity to present her/his case to a reviewing authority regarding what the client or her/his authorized representative perceives to be an inappropriate action by the state or any of its agents or providers. This can be a QOC concern or a general concern.

Appeal: A request on behalf of a client for a review of an action taken on a complaint or grievance.

b. X Please describe any special processes that the State has for persons with special needs.

We will assist in filling out paperwork and have a TDD system for people with hearing deficiencies. We work with our clients on an individual basis and assist as needed whenever we can. If a client has a special need that cannot be met by us we may refer to the county office or to an advocacy group. In either case we will work closely with the client and the other party to assist.

X Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

The complaints typically come into the help line that is staffed by our enrollment broker, ACS. The help line staff initially review the complaint. If the complaint cannot be resolved immediately it is referred to the appropriate person. This can include state personnel or county personnel.

X Specifies a time frame from the date of action for the enrollee to file a request for review, which is: *90 days* (please specify for each type of request for review)

This request is required for review of fair hearing decisions

X Has time frames for resolving requests for review. Specify the time period set: *20 Days* (please specify for each type of request for review)

State has within 20 calendar days of receiving a complaint.

___ Establishes and maintains an expedited review process for the following reasons: _____. Specify the time frame set by the State for this process____

X Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

X Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

___ Other (please explain):

F. Program Integrity

1. **Assurances.**

_X_ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
   a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

2. **Assurances For MCO or PIHP programs**

___ The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

___ State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under "Program Impact." However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

Network Adequacy Report – This report is a quarterly report. The NAR lists the ratio on a county-by-county basis as well as a statewide ratio. The county ratios range from 1:672 to 1:9. The maximum capacity Montana Medicaid allows for each provider is 1000.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

Nurse Advice Line vendor's activities are monitored on a monthly basis via the ACD report detailing number of calls received, number of calls abandoned, abandonment rate, call length and average talk time to assure clients access to the service. The program officer and analyst monitor reports including the Post Intent Report, callers are asked whether or not they agree with recommendations received from the Nurse Advice Line. In addition, staff will utilize our Client Data Survey System to verify client satisfaction with this service, and conduct annual on-site monitoring of the vendor's call center per the submitted Monitoring Procedures for the Care Management Section Contracts.

Nurse Advice Line is a benefit for eligible clients but not a required service. Clients are made aware of this benefit as part of their Medicaid coverage but are able to seek medical services from their PCP or other medical providers.

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.

- **PCCM and FFS selective contracting** programs – there must be at least on checkmark in each sub-column under "Evaluation of Program Impact." There must be at least one check mark in one of the three sub-columns under

"Evaluation of Access." There must be at least one check mark in one of the three sub-columns under "Evaluation of Quality."

- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication												
Accreditation for Participation												
Consumer Self-Report data	**PCCM**	**PCCM**	**PCCM/ EPCCM**		**PCCM NAL**	**PCCM/ EPCCM**	**PCCM**		**PCCM/ EPCCM**		**PCCM**	**PCCM/ EPCCM NAL**
Data Analysis (non-claims)	**PCCM**	**PCCM NAL**	**PCCM/ EPCCM**	**PCCM/ EPCCM**	**PCCM/ EPCCM NAL**	**PCCM/ EPCCM**	**NAL**	**PCCM**			**PCCM**	**NAL**
Enrollee Hotlines	**PCCM**	**PCCM**	**PCCM**		**PCCM**	**PCCM**	**PCCM**		**PCCM**		**PCCM**	**PCCM**
Focused Studies												
Geographic mapping	**PCCM/ EPCCM**							**PCCM**				
Independent Assessment												
Measure any Disparities by Racial or Ethnic Groups	**PCCM**		**PCCM/ EPCCM**		**PCCM/ EPCCM**						**PCCM**	
Network Adequacy Assurance by Plan	**PCCM/ EPCCM**							**PCCM/ EPCCM**			**PCCM/ EPCCM**	

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/ Continuity	Coverage/ Authorization	Provider Selection	Quality of Care
Ombudsman												
On-Site Review				**NAL**	**NAL**		**NAL**					**NAL**
Performance Improvement Projects												
Performance Measures				**EPCCM**								**EPCCM**
Periodic Comparison of # of Providers	**PCCM**	**PCCM/ EPCCM**						**PCCM**			**PCCM**	
Profile Utilization by Provider Caseload												
Provider Self-Report Data		**PCCM/ EPCCM**	**PCCM/ EPCCM**	**PCCM/ EPCCM**	**PCCM/ EPCCM**			**PCCM**	**PCCM/ EPCCM**			

II. Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ____ Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

b. _____ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

___ NCQA
___ JCAHO
___ AAAHC
___ Other (please describe)

c. X Consumer Self-Report data

___ CAHPS (please identify which one(s))
X State-developed survey
___ Disenrollment survey
___ Consumer/beneficiary focus groups

- *Passport to Health*
- *Montana Medicaid*
- *The State will conduct a confidential client survey by mail, using a computerized client survey tool. Clients will be selected at random to participate in the survey. Clients will be sent paper surveys and asked to rate services (satisfaction with Passport Provider's services, NAL, HIP, Client Helpline, etc.) on a relative scale.*
- *Survey's will be conducted on an annual basis*

- *Clients will be asked to rate Passport services they have received. This will enable the state to measure levels of satisfaction in our program and identify areas that clients are not happy with. On the survey, clients will be given an opportunity to make any additional comments regarding Medicaid services.*

d. X Data Analysis (non-claims)

___ Denials of referral requests
X Disenrollment requests by enrollee
___ From plan
X From PCP within plan
X Grievances and appeals data
X PCP termination rates and reasons
___ Other (please describe)

- *Passport to Health and Team Care*
- *Enrollment Broker and State*
- *Enrollment Broker prepares a monthly High Level Report which details client disenrollments, grievances and PCP terminations. In addition, Enrollment Broker forwards all written complaints/grievances to the state to be handled by program staff. State staff reviews the High Level Report and analyzes the data for trends which must be addressed*
- *Monthly*
- *High Level Report details the frequency of disenrollments, grievances and PCP terminations, which are closely monitored by the State.*

e. X Enrollee Hotlines operated by State

- *Passport to Health and Team Care*
- *Enrollment Broker and State*
- *Operation of the client helpline is a part of the Enrollment Broker contract. The State has set forth performance measures in the EB contract amendment to ensure the helpline is being operated efficiently and effectively. The EB prepares the monthly High Level Report and the EB Report Card which include details on call volume, speed of answer, abandonment rate, voluntary enrollment rate and outreach rate. The report data is collected from the helpline call software. State staff also routinely listens to calls and perform a yearly audit of the helpline functionality.*
- *monthly*
- *Details on call volume, speed of answer, abandonment rate, voluntary enrollment rate and outreach rate are analyzed to determine whether performance measures are being met.*

f. _____ Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

g. X Geographic mapping of provider network

- *Passport to Health*
- *Enrollment Broker and State*
- *Enrollment Broker prepares a quarterly Network Adequacy Report which details the number of Passport providers and clients in each county.*
- *quarterly*
- *State analyzes data to ensure adequate, statewide provider coverage.*

h. ____ Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

Independent Assessments have been completed and submitted for the first two waiver periods. The State is requesting that it not be required to arrange for additional Independent Assessments unless CMS finds reasons to request additional evaluations as a result of this renewal request. In these instances, CMS will notify the State that an Independent Assessment is needed in the waiver approval letter.

i. X Measurement of any disparities by racial or ethnic groups

- *Passport to Health*
- *State and Enrollment Broker*
- *Enrollment Broker monthly High Level Report details enrollment into Passport by race.*
- *monthly*
- *State analyzes data for any disparities between choice enrollment and auto-assignment depending on race.*

j. X Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

- *Passport to Health*
- *Enrollment Broker and State*
- *Enrollment Broker prepares a quarterly Network Adequacy Report which details provider to enrollee ratios by county, PCP caseload and limits by county, measurement of enrollee requests for*

disenrollment from a PCP due to capacity issues, open PCCM slots by county and provider type, tracking of complaints and grievances related to capacity.

- *quarterly*
- *State analyzes data to ensure adequate, statewide provider coverage.*

k. _____ Ombudsman

l. _____ On-site review

m. _____ Performance Improvement projects [**Required** for MCO/PIHP]

___ Clinical

___ Non-clinical

n. _____ Performance measures [**Required** for MCO/PIHP]

Process
Health status/outcomes
Access/availability of care
Use of services/utilization
Health plan stability/financial/cost of care
Health plan/provider characteristics
Beneficiary characteristics

o. X Periodic comparison of number and types of Medicaid providers before and after waiver

- *Passport to Health*
- *Enrollment Broker and State*
- *Enrollment Broker prepares a quarterly Network Adequacy Report which details provider to enrollee ratios by county, and types of providers.*
- *quarterly*
- *State analyzes data to ensure an adequate number and range of providers are available statewide.*

p. ____ Profile utilization by provider caseload (looking for outliers)

q. X Provider Self-report data

X Survey of providers
We periodically survey providers.

___ Focus groups

- *Passport to Health*
- *State staff*
- *The State will conduct a provider survey by mail, using a computerized survey tool. Providers will be sent paper surveys*

and asked to rate their experience with Passport and to offer any suggestions for improving the program.

- *Survey's will be conducted on an annual basis*
- *This will enable the state to measure levels of satisfaction in our program, identify areas that providers are not happy with and perhaps, give the state suggestions for improvements.*

r. X Test 24 hours/7 days a week PCP availability

- *Passport to Health*
- *Enrollment Broker*
- *Enrollment Broker makes calls to providers after hours to ensure they have a message that directs clients to care 24/7.*
- *Testing occurs weekly*
- *Enrollment Broker ensures necessary coverage is available to clients by testing provider's phone lines after hours.*

s. X Utilization review (e.g. ER, non-authorized specialist requests)

- *Passport to Health*
- *Enrollment Broker*
- *Enrollment Broker randomly audits provider referrals by looking at billed claims with referral numbers, contacting referring providers and determining whether the referral was authorized by the Passport provider.*
- *Referral auditing is an ongoing process, and is conducted at least weekly.*
- *Contacting providers to determine whether they authorized referrals enables EB to determine which providers are storing Passport numbers and using them for unauthorized referrals.*

t. ___ Other: (please describe)

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

___ This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

_X_ This is a renewal request.

___ This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.

_X_ The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

Strategy:
Confirmation it was conducted as described:

___ Yes
___ No. Please explain:

Summary of results:
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

Consumer Self-Report data

___ CAHPS (please identify which one(s))
_X_ State-developed survey
___ Disenrollment survey
___ Consumer/beneficiary focus groups

Strategy: *Survey client satisfaction of the Passport program and Passport providers.*
Confirmation it was conducted as described:

Yes
_X_ No. Please explain:

Previously, a client survey was part of our enrollment broker contract. Our current EB contract does not require an annual client survey. The state has decided we will conduct a client survey independently using a client data survey tool (CDS) system developed by department IT staff. However, due to the efforts of state staff over-seeing the corrective action plan with our EB, and the fact that many Passport eligibles were not enrolled for some time, we were unable to complete a client survey during the previous waiver period. The state will complete a client survey in SFY 2010.

See Attachment I: Client Survey

Summary of results:
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

Data Analysis (non-claims)

___ Denials of referral requests
_X_ Disenrollment requests by enrollee
  ___ From plan
  _X_ From PCP within plan
_X_ Grievances and appeals data
_X_ PCP termination rates and reasons
___ Other (please describe)

Strategy: *To monitor provider's client disenrollment, grievances and appeals and termination of PCPs from the Passport program.*
Confirmation it was conducted as described:

_X_ Yes

No. Please explain:

Summary of results: *The High Level Report provided by our enrollment broker reflects client and provider disenrollment. We look for trends or areas of concern such as frequent, mass disenrollment of clients by a single provider. Since our enrollment broker has been fully functional we have not had any areas of major concern.*

All grievances and appeals come directly to the State. We monitor grievances and appeals for trends and follow-up if necessary. There have been no major concerns or fluctuations in grievances during this waiver period.

See Attachment J: Enrollment Broker High Level Report

Problems identified: None

Corrective action (plan/provider level)

Program change (system-wide level)

Enrollee Hotlines operated by State

Strategy: *Ensure that our Medicaid Client Help Line (operated by our enrollment broker, ACS) is effectively reaching performance standards set forth in our contract. The monthly High Level Report and EB Report Card include call volume, speed of answer, abandonment rate, voluntary enrollment rate and outreach rate. The report data is collected from the helpline call software. State staff also routinely listens to calls and perform a yearly audit of the helpline functionality.*

See Attachment J: Enrollment Broker High Level Report

Attachment K: Enrollment Broker Report Card

Attachment L: 2009 State Enrollment Broker Audit Report

Confirmation it was conducted as described:

_X_ Yes

No. Please explain:

Summary of results: *No major issues have been identified since our enrollment broker has been fully functional.*

Problems identified: None

Corrective action (plan/provider level)

Program change (system-wide level)

Geographic mapping of provider network

Strategy: *Ensure adequacy of provider network. Network Adequacy Report (NAR) attached- includes a client/provider ratio for each county.*

See Attachment M: Network Adequacy Report

Confirmation it was conducted as described:

_X_ Yes

No. Please explain:

Summary of results: *Two additional counties (McCone & Sanders) are now participating in Passport making the program statewide. There have been no major issues with our network adequacy during this waiver period.*

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level): *Program is now statewide*

Measurement of any disparities by racial or ethnic groups
Strategy: *Monitor for disparities between racial or ethnic groups and program enrollment and auto assignment versus voluntary program enrollment. Disparities are monitored through the High Level Report and the Monthly Managed Care Report prepared by the Managed Care Analyst.*
See Attachments J: Enrollment Broker High Level Report
Attachment N: Monthly Managed Care Report
Confirmation it was conducted as described:
_X_ Yes
___ No. Please explain:
Summary of results: *No racial or ethnic disparities have been identified in our managed care programs or enrollment.*
Problems identified: None
Corrective action (plan/provider level)
Program change (system-wide level)

Network adequacy assurance submitted by plan
Strategy: *Monitor provider network adequacy, specifically; provider to enrollee ratios by county, PCP caseload and limits by county, measurement of enrollee requests for disenrollment from a PCP due to capacity issues, open PCCM slots by county and provider type, tracking of complaints and grievances related to capacity. This data is monitored through the Network Adequacy Report.*
See Attachment M: Network Adequacy Report
Confirmation it was conducted as described:
_X_ Yes
___ No. Please explain:
Summary of results: *No major issues have been identified.*
Problems identified: None
Corrective action (plan/provider level)
Program change (system-wide level)

Periodic comparison of number and types of Medicaid providers before and after waiver
Strategy: *Ensure availability of a range of providers to populations covered under this waiver. The NAR tracks the ratio of providers to clients by county. The state closely monitors complaints about access to providers.*
See Attachment M: Network Adequacy Report
Confirmation it was conducted as described:
_X_ Yes
___ No. Please explain:
Summary of results: *No major issues have been identified regarding availability of providers.*
Problems identified:
Corrective action (plan/provider level)

Program change (system-wide level)

Provider Self-report data

_X_ Survey of providers
We periodically survey providers.
___ Focus groups

Strategy: *Use CDS (state client data survey tool) system to survey provider satisfaction with the Passport program.*
Confirmation it was conducted as described:

Yes
_X_ No. Please explain: *During this waiver period the state did not perform a provider survey. State staff time was very focused on our new vendor, the corrective action plan and the implementation of enrollment broker after two years without full functionality. We are currently working with state IT staff to import provider data into the CDS system which would enable us to survey a random sample of Passport Providers. We will complete a survey in SFY 2010.*

Summary of results:
Problems identified:
Corrective action
Program change (system-wide level)

Test 24 hours/7 day week PCP availability

Strategy: *Test the 24/7 availability of Passport providers by calling their after-hours line to determine what course of action they advise their patients to take in order to receive care.*
See Attachment O: Provider Line Availability Audit
Confirmation it was conducted as described:

_X_ Yes
No. Please explain:

Summary of results: *The Passport Provider Lead at ACS frequently conducts test phone calls before and after regular business hours.*
Problems identified: *Problems have been identified with some providers not offering direction for after-hours care on their 24 hour line.*
Corrective action (plan/provider level) *Providers are educated about their obligation to offer direction for care 24/7 and their number is retested.*
Program change (system-wide level)

Utilization review (e.g. ER, non-authorized specialist requests)

Strategy: *Identify where Passport referral numbers have been used but not authorized. We randomly audit Passport referrals by looking at claims and contacting referring providers to confirm they have given the referral.*
See Attachment P: Passport Referral Audit Report
Confirmation it was conducted as described:

_X_ Yes
No. Please explain:

Summary of results: *Some providers are not keeping adequate records of referrals making it impossible to audit the use of their numbers. In several cases, we have found misuse of Passport numbers resulting in claims being paid that were not properly referred.*
Problems identified: *Lack of record keeping; misuse of Passport referral numbers Funds have been recouped in several cases. We have educated providers about the requirement that they keep documentation of every time they refer a Passport client.*
Corrective action (plan/provider level) *Providers who have not kept adequate records will be asked to provide lists of referrals 6 months after they have been educated about this requirement.*
Program change: (system-wide level)

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

Appendix D1. Member Months
Appendix D2.S Services in the Actual Waiver Cost
Appendix D2.A Administration in the Actual Waiver Cost
Appendix D3. Actual Waiver Cost
Appendix D4. Adjustments in Projection
Appendix D5. Waiver Cost Projection
Appendix D6. RO Targets
Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State's CMS Regional Office.

Part I: State Completion Section

A. Assurances

a. X [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost

Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.

- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

b. Name of Medicaid Financial Officer making these assurances: Mary LeMieux

c. Telephone Number: 406-444-1921

d. E-mail: MLeMieux2@mt.gov

e. The State is choosing to report waiver expenditures based on
_X date of payment.
__ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

a.___ The State provides additional services under 1915(b)(3) authority.

b.___ The State makes enhanced payments to contractors or providers.

c.___ The State uses a sole-source procurement process to procure State Plan services under this waiver.

d.___ Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b**.

a.___ MCO
b.___ PIHP
c. ___ PAHP
d.___ Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a._X_ Management fees are expected to be paid under this waiver. The management fees were calculated as follows.

Passport to Health

1._X_ First Year: $ 3.00 per member per month fee
2._X_ Second Year: $ 3.00 per member per month fee
3._X_ Third Year: $ 3.00 per member per month fee
4._X_ Fourth Year: $ 3.00 per member per month fee

Team Care

1._X_ First Year: $ 6.00 per member per month fee
2._X_ Second Year: $ 6.00 per member per month fee
3._X_ Third Year: $ 6.00 per member per month fee
4._X_ Fourth Year: $ 6.00 per member per month fee

b._X Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

1.X First Year: $3.75 per member per month fee
2.X Second Year: $3.75 per member per month fee
3.X Third Year: $3.75 per member per month fee
4.X Fourth Year: $3.75 per member per month fee

Case management fee for enhanced PCCM was determined through consultation with PCCM Provider Network and with consideration of the expenses incurred under the former disease management program. Additional services include:

- Conduct patient health assessment within 30 days of Department referral of patient to Provider, using an approved Health Survey. Patients who cannot be reached or who prefer not to participate in an assessment initially are placed in "on demand" status and additional contact attempts are made at least twice during the following 12 months.
- Provide initial and ongoing clinical assessment at pre-determined intervals such as 30, 60, 90 days and one year, depending on diseases and risks.
- Tailor a holistic treatment/action plan for each enrolled patient in consultation with patient's primary care provider.
- Manage patients as indicated—in person, telephonically, or other means suited to the individual.
- Provide group appointments for education and prevention when appropriate.
- Monitor and remind patients about routine testing; provide follow-up education regarding tests.
- Coordinate services with existing partners and form new partnerships (examples—hospitals, community primary care providers, social service and non-profit programs).
- Participate in multi-disciplinary hospital pre-discharge planning and counseling.
- Provide post hospital discharge visits, in-person and/or telephonic.
- Educate and support patients in self-management of health conditions.
- Be familiar with and refer patients to available local resources that can help patients with social services, housing, and other life problems that could prevent patients from paying attention to medical conditions.
- Track patient data—enrollment status, diseases, risks, interventions, and outcomes—and report to the Department.
- In conjunction with the Department, incorporate new methods such as remote disease monitoring or virtual video visits as technology is available and appropriate.
- Monitor patient progress and determine criteria for completion/graduation.

c.___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d.___ Other reimbursement method/amount. $_____ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

a.___ Population in the base year data
  1.___ Base year data is from the same population as to be included in the waiver.
  2. __ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)

b.___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.

c.___ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
_____

d. ___ [Required] Explain any other variance in eligible member months from BY to P2: _____

e.____ [Required] List the year(s) being used by the State as a base year:____. If multiple years are being used, please explain:_____

f.____ [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period _____.

g.____ [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data:
_____

For Conversion or Renewal Waivers:

a._X_ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b.____ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*

c._X_ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

The member months of Medicaid Eligibility Groups will change as follows:

Passport SSI, Passport TANF, EPCCM, NAL:

The change in member months for these population groups are based on experience in R1 and R2 factoring unemployment / expected unemployment and natural growth within demographics.

Passport HK, EPCCM HK, and NAL HK:

With no previous data, the Medicaid expansion group for P1 was projected based on the number of children reaching their annual CHIP renewal date who will qualify for the expansion group and the number of children who will qualify based on the asset test changes. In addition to the projections identified in P1, P2 includes the factoring of unemployment/ expected unemployment and natural growth within demographics.

d. _X_ [Required] Explain any other variance in eligible member months from BY/R1 to P2: __There are none__

e._X_[Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

R1/ R2 are neither state nor fiscal year. The dates are based on the previous waiver period. R1 runs from April 1, 2008 to March 31, 2009. R2 runs from April 1, 2009 through June 30, 2009.

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

a.___ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

For Conversion or Renewal Waivers:

a._X_ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made on **Appendix D5**: _

Changes to D2.S services include enhanced case management fees for the EPCCM and EPCCM HK populations as well as fees for the Nurse Advice Line and Nurse Advice Line HK populations

b._X_ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: _There were no excluded services

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

For Initial Waivers:

a. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

Additional Administration Expense	**Savings projected in State Plan Services**	**Inflation projected**	**Amount projected to be spent in Prospective Period**
(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*Appendix D5 should reflect this.*		*Appendix D5 should reflect this.*

The allocation method for either initial or renewal waivers is explained below:

a.___ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

b.___ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*

c._X_ Other (Please explain).

In Montana, we have seven MEGs. Three of our MEGs are PCCM, two are EPCCM, and the final two are NAL. The actual administrative expenditures for R1 and R2 were separated into PCCM (PPSSI/PPTANF) costs. EPCCM and NAL did not have admin costs for R1 and R2 as these Medicaid Eligibility Groups were not established until after quarter ending 06/30/2009.

Administrative costs for the Medicaid/CHIP expansion groups (PPHK/EPCCMHK/NALHK) are not included.

Projected administrative costs for P1 and P2 were calculated by applying the enrollment broker amount to the PCCM MEGs (PPSSI/PPTANF). The remaining administrative costs were applied to each MEG on a PMPM basis. (Excluding the Medicaid/CHIP expansion groups)

H. Appendix D3 – Actual Waiver Cost

a.___ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	**Savings projected in State Plan Services**	**Inflation projected**	**Amount projected to be spent in Prospective Period**
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$54,264 savings or .03 PMPM*	*9.97% or $5,411*	*$59,675 or .03 PMPM P1* *$62,488 or .03 PMPM P2*
Total	*(PMPM in Appendix D5 Column T x projected member months should correspond)*		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State's Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State's Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)	*$1,751,500 or $.97 PMPM R1* *$1,959,150 or $1.04 PMPM R2 or BY in Conversion*	*8.6% or $169,245*	*$2,128,395 or 1.07 PMPM in P1* *$2,291,216 or 1.10 PMPM in P2*
Total	**(PMPM in Appendix D3 Column H x member months should correspond)**		**(PMPM in Appendix D5 Column W x projected member months should correspond)**

b.___ The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

c.__ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of

coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1.___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.

2.___ The State provides stop/loss protection (please describe):

d.____Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1.____ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs **(Column D of Appendix D3 Actual Waiver Cost).** Regular State Plan service capitated adjustments would apply.

i. Document the criteria for awarding the incentive payments.

ii. Document the method for calculating incentives/bonuses, and

iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2.____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs **(Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program **(See D.I.I.e and D.I.J.e)**

i. Document the criteria for awarding the incentive payments.

ii. Document the method for calculating incentives/bonuses, and

iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

   1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

   2.___ [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

      i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

ii.____ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used_____. Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3.____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).

ii. Please document how the utilization did not duplicate separate cost increase trends.

b. __ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2.___ An adjustment was necessary. The adjustment(s) is(are) listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

iv.__ Changes in legislation (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v.__ Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

c.___ **Administrative Cost Adjustment*:** The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population

participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2.___ An administrative adjustment was made.

i.___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____Other (please describe):

ii.___ FFS cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____Other (please describe):

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. **1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in **Section D.I.H.a** above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the State's trend for State Plan Services.

i. State Plan Service trend

A. Please indicate the State Plan Service trend rate from **Section D.I.I.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.I.a**._____

2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____

3. Explain any differences:

f. **Graduate Medical Education (GME) Adjustment**: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1.___ We assure CMS that GME payments are included from base year data.

2.___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)

3.___ Other (please describe):

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this

change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1.___ GME adjustment was made.
   i.___ GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe).
   ii.___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2.___ No adjustment was necessary and no change is anticipated.

Method:

1.___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine GME adjustment based on a pending SPA.
3.___ Determine GME adjustment based on currently approved GME SPA.
4.___ Other (please describe):

g. **Payments / Recoupments not Processed through MMIS Adjustment:** Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in **Appendix D5.**

1. X Payments outside of the MMIS were made. Those payments include (please describe):
   Services for clients included on the NAL and NALHK MEGs are paid outside of the MMIS system. These payments are processed through the state's AWACS payment system.

   Case Management Fees for American Indian clients who are enrolled with an I.H.S. facility under the PCCMSSI, PCCMTANF, or PCCMHK eligibility groups are paid outside of the MMIS system through AWACS.

2.___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):
3.___ The State had no recoupments/payments outside of the MMIS.

h. **Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1.___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.

2.___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3.___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4.___ Other (please describe):

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.
1.___ No adjustment was necessary and no change is anticipated.
2___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:
1.___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2.___ Determine copayment adjustment based on pending SPA.
3.___ Determine copayment adjustment based on currently approved copayment SPA.
4.___ Other (please describe):

i. **Third Party Liability (TPL) Adjustment**: This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.
Basis and method:
1.___ No adjustment was necessary
2.___ Base Year costs were cut with post-pay recoveries already deducted from the database.
3.___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees
4.___ The State made this adjustment:*
i.___ Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5.**
ii.___ Other (please describe):

j. **Pharmacy Rebate Factor Adjustment** : Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

k. **Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1.___ We assure CMS that DSH payments are excluded from base year data.

2.___ We assure CMS that DSH payments are excluded from the base year data using an adjustment.

3.___ Other (please describe):

l. **Population Biased Selection Adjustment** (Required for programs with Voluntary Enrollment): Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1.___ This adjustment is not necessary as there are no voluntary populations in the waiver program.

2.___ This adjustment was made:

a. ___Potential Selection bias was measured in the following manner:

b.___The base year costs were adjusted in the following manner:

m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.

1.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
2.___ We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
3.___ ***We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.***
4.___ Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:
The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

a.___ The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
b.___ The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

Special Note for initial combined waivers (Capitated and PCCM) only:
Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	**Capitated Program**	**PCCM Program**
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem

Adjustment	Capitated Program	PCCM Program
	Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

n. **Incomplete Data Adjustment (DOS within DOP only)**– The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including "lag factors," "incurred but not reported (IBNR) factors," or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1.___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:

2.___ The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.

3.___ Other (please describe):

o. **PCCM Case Management Fees (Initial PCCM waivers only) –** The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees. The new PCCM case management fees will be accounted for with an adjustment on **Appendix D5.**

1.___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.

2.___ This adjustment was made in the following manner:

p. **Other adjustments**: Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.

- ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
- ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

1.___ No adjustment was made.

2.___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

a. X **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The**

State must document how it ensures there is no duplication with programmatic/policy/pricing changes.

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period *(i.e., trending from 1999 to present)* The actual trend rate used is: _____. Please document how that trend was calculated:

2._X_ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) *(i.e., trending from present into the future)*.

i. _X__ State historical cost increases. Please indicate the years on which the rates are based: base years April 1, 2008-March 31, 2009 and April 1, 2009-June 30, 2009. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM. The state's cost increase for state plan service trend calculation does not include additional factors.

The adjustment was due to a trend analysis that was completed based on prior years for the State of Montana. A health care trend analysis is completed at the end of each year. This analysis is based on the prior three years. The inflation rate is calculated for each year and then average for the three years. The average inflation rate of 6.1% is used in the calculations for this waiver.

This adjustment was not applied to the EPCCM or NAL MEGS as service costs for these population groups will not be affected by trending increases.

ii. ___ National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3._X__The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented

how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

i. Please indicate the years on which the utilization rate was based (if calculated separately only).
R1 and R2 (Complete quarters only) which runs from April 2008-June 2009

ii. Please document how the utilization did not duplicate separate cost increase trends.

Legislative rate increase was calculated separate from state plan trending.

b. _X__ **State Plan Services Programmatic/Policy/Pricing Change Adjustment:**
These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.
Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1.___ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2._X_ An adjustment was necessary and is listed and described below:

i.__ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods. For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Determine adjustment for Medicare Part D dual eligibles.

E.____ Other (please describe):

ii.__ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii.__ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:

iv.__ Changes brought about by legal action (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

v.__ Changes in legislation (please describe):
For each change, please report the following:

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D.____Other (please describe):

vi. X Other (please describe):

A.____The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____

B.____The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____

C.____Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. _X_Other (please describe):

This adjustment was due to a legislative rate increase of 3.0% which is applied to both P1 and P2.

The legislative adjustment was not applied to the EPCCM or NAL MEGS as service costs for these populations groups will not be affected by legislative increases.

c. _X__ **State Administrative Cost Adjustment:** This adjustment accounts for **changes** in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1.___ No adjustment was necessary and no change is anticipated.

2._X__An administrative adjustment was made.

i.___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:

ii.___ Cost increases were accounted for.

A.____Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).

B.____Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).

C.____State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:

D.__X__Other (please describe):

The State has not cost effective on administrative expenditures in the past. Adjustments were needed to more closely project administrative costs.

Prospective Year 1

The state projects an increase to administrative costs of 10% for P1. This increase will account for the estimated cost of building and implementing a case management data base for the EPCCM program as well as implementation of a survey database for all 1915(b) programs.

Prospective Year 2

The state projects a 3% reduction for P2. Once the state has completed implementation of the case management and survey data bases in P1, implementation fees will be finalized and only a maintenance fee will continue into P2. In addition, due to the economic downturn the state expects a decrease in travel expenditures.

iii.___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

d. **1915(b)(3) Trend Adjustment:** The State must document the amount of 1915(b)(3) services in the R1/R2/BY **Section D.I.H.a** above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1.___ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual

State historical trend to project past data to the current time period *(i.e., trending from 1999 to present).* The actual documented trend is: _____. Please provide documentation.

2.___ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future *(i.e., trending from present into the future)*, the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years_____
2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a**. above _____.

e. **Incentives (not in capitated payment) Trend Adjustment:** Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from **Section D.I.J.a** _____

2. List the Incentive trend rate by MEG if different from **Section D.I.J.a**. _____

3. Explain any differences:

f. **Other Adjustments** including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - ♦ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - ♦ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)****: Rebates that States receive from drug manufacturers should be

deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.
Basis and Method:

1.___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population ***which includes accounting for Part D dual eligibles***. Please account for this adjustment in **Appendix D5**.

2.___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS ***or Part D for the dual eligibles***.

3.___ Other (please describe):

1. _X_ No adjustment was made.
1.___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.
   1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

      The member months of Medicaid Eligibility Groups will change as follows:

      Passport SSI, Passport TANF, EPCCM, NAL:

The change in member months for these population groups are based on experience in R1 and R2 factoring unemployment / expected unemployment and natural growth within demographics.

Passport HK, EPCCM HK, and NAL HK:

With no previous data, the Medicaid expansion group for P1 was projected based on the number of children reaching their annual CHIP renewal date who will qualify for the expansion group and the number of children who will qualify based on the asset test changes. In addition to the projections identified in P1, P2 includes the factoring of unemployment/ expected unemployment and natural growth within demographics.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

   The adjustment was due to a trend analysis that was completed based on prior years for the State of Montana.
   A health care trend analysis is completed at the end of each year. This analysis is based on the prior three years. The inflation rate is calculated for each year and then average for the three years. This average inflation rate is the rate used in the calculation for this waiver.
   This adjustment was not applied to the EPCCM or NAL MEGS as service costs for these population groups will not be affected by trending increases.

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I.** This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

   This adjustment was due to a legislative rate increase that was applied to both P1 and P2. The legislative adjustment was not applied to the EPCCM or NAL MEGS as service costs for these population groups will not be affected by legislative increases.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I.**

Part II: Appendices D.1-7

Please see attached Excel spreadsheets.